COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET, ROOM 525
LOS ANGELES, CALIFORNIA 90012-3873
PHONE: (213) 974-8301 FAX: (213) 626-5427

JOHN NAIMO
AUDITOR-CONTROLLER

April 26, 2016

TO: Cynthia Harding, M.P.H., Interim Director
Department of Public Health

FROM: John Naimo
Auditor-Controller

SUBJECT: **HIPAA AND HITECH ACT PRIVACY COMPLIANCE REVIEW – RUTH TEMPLE HEALTH CENTER**

We have completed a review of the Department of Public Health (DPH) Ruth Temple Health Center's (Ruth Temple) compliance with the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic Clinical Health (HITECH) Act.[1] On February 19, 2016, we provided your Department with our final draft report. DPH Community Health Services (CHS) management generally agreed with our findings and indicated that a formal exit conference was unnecessary. This report includes our findings, recommendations for corrective action, and your Department's response.

Overall Summary

At the time of our review, Ruth Temple was substantially in compliance with each of the nine areas we assessed, and we noted only two minor areas of noncompliance. We found no significant deficiencies in Ruth Temple's HIPAA and HITECH program. We made two recommendations, which Ruth Temple and DPH management have already implemented or have agreed to implement. Attachment I is a matrix describing the nine areas we assessed and the results. DPH's response is included as Attachment II.

Approach/Scope

Our approach and scope considered that Ruth Temple is a relatively small clinic and is one of the three public health centers administered by CHS that provides services in

[1] 45 Code of Federal Regulations (CFR) Parts 160 and 164

Service Planning Areas (SPA) 5/6. Similar to other DPH public health centers, Ruth Temple offers screening and treatment for sexually transmitted diseases.

On November 10, 2015, we conducted a comprehensive on-site review to evaluate Ruth Temple's compliance with the HIPAA Privacy Rule. We met with DPH's Privacy Officer and CHS' Acting Deputy Administrative Director, as well as Ruth Temple's Facility Administrator, Nurse Manager, and the SPA 5/6 Administrator and Medical Director. SPA 5/6 administration is responsible for overseeing Ruth Temple's Privacy and Security Program, which includes HIPAA compliance.

Our review utilized the *HIPAA Privacy Rule and Health Information Technology for Economic Clinical Health (HITECH) Program Check List/Audit Tool* in evaluating Ruth Temple's compliance with the HIPAA Privacy Rule and DPH's HIPAA policies and procedures. SPA 5/6 management is responsible for establishing and maintaining effective internal compliance with the HIPAA regulations, and has oversight of the HIPAA program throughout their three facilities, including Ruth Temple. We considered Ruth Temple's internal controls over their compliance program, DPH policies, and the HIPAA Privacy Rule requirements that could have a direct and material effect on Ruth Temple.

Our review covered the HIPAA Privacy Rule requirements for:

- Notice of Privacy Practices (NPP) for protected health information (PHI)
- Safeguards for PHI
- Training
- Complaint process
- Uses and disclosures requiring authorization
- Accounting for disclosures of PHI
- HITECH Act breach notification
- Appropriate access to electronic PHI (ePHI)
- Contingency plan

Our review also examined, on a limited basis, Ruth Temple's compliance with certain aspects of the Security Rule where there was cross-over with the Privacy Rule. These included administrative, physical, and technical safeguards.

Results of Review and Recommendations

Notice of Privacy Practices for Protected Health Information

The HIPAA Privacy Rule requires a covered entity with direct treatment relationships with individuals to give the NPP to every individual no later than the date of first service delivery, and to make a good faith effort to obtain the individual's written acknowledgment of receipt of the NPP. If the provider maintains an office or other

physical site where care is provided directly to individuals, the provider must also post the NPP in the facility in a clear and prominent location where individuals are likely to see it, as well as make the NPP available to those who ask for a copy.[2]

During our on-site visit, we observed the current DPH NPP in prominent locations near the facility's patient reception area, which is where visitors of the facility are most likely to see it. In addition, the NPP is available on the main page of DPH's website, which includes links to the NPP in both English and Spanish.

Currently, Ruth Temple maintains patient NPP Acknowledgment forms in their physical patient charts. We randomly selected and reviewed ten patients' medical charts to determine whether Ruth Temple obtained patients' NPP Acknowledgments. We noted that all ten (100%) contain a signed NPP Acknowledgment.

DPH's NPP satisfies the HIPAA requirements, and it appears that Ruth Temple appropriately documents and maintains patients' NPP Acknowledgments per HIPAA standards.

Safeguards for Protected Health Information

A covered entity must have in place appropriate administrative, physical, and technical safeguards to protect the privacy of PHI. A covered entity must reasonably safeguard PHI and ePHI, and make reasonable efforts to prevent any intentional or unintentional use or disclosure that violates the HIPAA Privacy Rule.

During our review, we observed that Ruth Temple's restricted areas, including the medical records room, are locked and accessible only to employees. According to Ruth Temple management, authorized personnel are assigned keycards to access restricted areas. Ruth Temple management indicated that only assigned staff have access to the medical records room. Ruth Temple uses several mechanisms to track medical records, including a business office daily chart tracking log, and collects charts at the end of each day. Each chart includes a "route sheet" that tracks access.

We also observed that the computer monitors near public areas were positioned away from public view so that the information was not readable. Fax machines, printers, and copiers were kept in secure areas and away from visitors. It appears that the workstations are compliant with the HIPAA standards.

It appears that Ruth Temple has implemented appropriate Privacy Rule safeguards for PHI.

[2] 45 CFR § 164.520(c)

Training

A covered entity must train all members of its workforce on policies and procedures related to PHI that are required by the HIPAA Privacy and Security Rules to the extent necessary and appropriate for the members of its workforce to carry out their functions. Members of the workforce include employees, volunteers, and trainees.[3]

Prior to our on-site review, CHS management stated that all Ruth Temple workforce members had received training on the HIPAA Privacy and Security Rules, HITECH Act's Breach Notification Rule, and DPH's HIPAA policies and procedures. DPH's Privacy Officer provided us with a report on HIPAA training status for Ruth Temple staff. Our review of Ruth Temple's training records showed that 19 (100%) out of 19 workforce members have completed the required HIPAA training.

In addition, SPA 5/6 administrators created a specialized HIPAA PowerPoint presentation for workforce members to provide role-based training. We reviewed the associated training materials and noted that they appear to be appropriate for the intended purpose. On November 4, 2015, Ruth Temple staff were provided with the training and presentation.

It appears that DPH and Ruth Temple have an effective HIPAA training program that meets the HIPAA training standards.

Complaint Process

A covered entity must provide a process for individuals to make complaints concerning the covered entity's policies and procedures. A covered entity must document all complaints received, and their disposition, if any.[4]

We reviewed Ruth Temple's HIPAA privacy investigation process. Patients may request complaint forms from reception staff. Complaint investigations are conducted by SPA 5/6 management, and the complaint disposition is maintained by DPH's Human Resources Division. According to SPA 5/6 management, Ruth Temple has not received a HIPAA complaint within the last year.

We reviewed draft DPH Policy 1224, *Complaints related to the privacy of Protected Health Information (PHI)*, and noted that it complies with HIPAA regulations. It appears that Ruth Temple has an appropriate complaint process and that management and staff are aware of DPH's procedures for handling HIPAA-related complaints.

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[3] 45 CFR § 164.530(b)
[4] 45 CFR § 164.530(d)

Uses and Disclosures Requiring Authorization

Guidance from the Office for Civil Rights (OCR) states that an authorization is a detailed document that gives covered entities permission to use PHI for specified purposes, which are generally other than treatment, payment, or health care operations, or to disclose PHI to a third party specified by the individual. An authorization must specify a number of elements, including: (1) a description of the PHI to be used and disclosed, (2) the person authorized to make the use or disclosure, (3) the person to whom the covered entity may make the disclosure, (4) an expiration date, and, in some cases, (5) the purpose for which the information may be used or disclosed.

Discussions with Ruth Temple management confirmed that workforce members have a general understanding of draft DPH Policy 1204, *Use and disclosure of protected health information requiring authorization,* which addresses uses and disclosures requiring an authorization from patients or their legal representatives and adhere to the policies.

We reviewed the DPH Policy and authorization form and noted that they meet the uses and disclosures requiring authorization standard.

Accounting for Disclosures of Protected Health Information

An individual has a right to receive an accounting for disclosures of PHI made by a covered entity. Covered entities are required to account to individuals for certain non-routine disclosures of PHI. The Privacy Rule gives individuals the right to request and receive an accounting for all disclosures of their PHI made by the covered entity, with certain exceptions, up to six years after the disclosure. The types of disclosures that are not required to be reported are disclosures:

- to the individual
- for treatment, payment, and health care operations
- for facility directories
- pursuant to authorization
- pursuant to a limited data set agreement
- to persons involved in the individual's care
- for correctional institutions
- for certain law enforcement purposes

Accounting for disclosures for Ruth Temple patients are maintained centrally by SPA 5/6 administrators. As of November 10, 2015, per the Chief HIPAA Privacy Officer's (CHPO) recommendation, an accounting for disclosures log has been placed in each Ruth Temple patient's medical chart. Ruth Temple has never received a request for an accounting for disclosures.

Recommendation

1. **Ruth Temple Health Center management ensure that an accounting for disclosures log has been placed in each patient's medical chart, and any disclosures outside the treatment, payment, or health care operations' exceptions are logged accordingly.**

HITECH Act Breach Notification

The U.S. Department of Health and Human Services (HHS) issued regulations requiring health care providers, health plans, and other entities covered by HIPAA to notify individuals when their health information is breached. These "breach notification" regulations implement provisions of the HITECH Act, passed as part of the American Recovery and Reinvestment Act of 2009. The regulations developed by OCR require health care providers and other HIPAA covered entities to promptly notify affected individuals of a breach, as well as the HHS Secretary and the media in cases where a breach affects more than 500 individuals. Breaches affecting fewer than 500 individuals will be reported to the HHS Secretary on an annual basis. The regulations also require business associates of covered entities to notify the covered entity of breaches at or by the business associate.

Ruth Temple administrators stated that staff received training on the breach reporting requirements, both through the County's centralized HIPAA Learning Management System and in a SPA 5/6-specific presentation, which we reviewed.

According to Ruth Temple administrators, their facility has not experienced a breach of PHI or ePHI. However, Ruth Temple administrators and management appear to be familiar with HIPAA breach notification requirements and DPH's breach notification policies and procedures.

Appropriate Access to ePHI

The Security Rule requires covered entities to have policies and procedures to ensure that workforce members have appropriate access to ePHI, and to prevent those workforce members who do not have access from obtaining access to ePHI. [5]

Ruth Temple maintains ePHI in the Public Health Information System (PHIS), which DPH uses for patient registration at all public health centers. According to DPH's Information Security Officer (ISO), PHIS access is restricted to staff who require it. PHIS also records user activity. PHIS saves data to a remote server but not to the hard drive of the device from which it's being accessed.

It appears that DPH and Ruth Temple appropriately monitor access to ePHI.

[5] 45 CFR § 164.308(a)(3)(i)

Contingency Plan

The Security Rule includes requirements for covered entities to ensure the confidentiality, integrity, and availability of all ePHI they create, receive, maintain, or transmit. The Security Rule further requires that covered entities protect against any reasonably anticipated threats or hazards to the security or integrity of such information, and requires covered entities to have policies and procedures for responding to emergencies or other occurrences (for example, fire, vandalism, system failure, and natural disaster) that damage systems containing ePHI. Contingency plans must be implemented and tested. [6]

DPH's ISO informed us that PHIS data is backed up centrally at DPH headquarters. DPH maintains an inventory of critical information technology components listed by priority for disaster recovery purposes. As part of the planned health services consolidation, DPH is scheduled to transfer their data to the Online Real-time Centralized Health Information Database (ORCHID), the Department of Health Services' electronic medical record system, in 2017. ORCHID data is encrypted and replicated between two data centers located remotely and maintained by Cerner, a County contractor.

We noted that Ruth Temple does not have a written contingency plan. Subsequent to our review, Ruth Temple administrators stated that they would work with DPH's CHS administration to create a written set of operational procedures in case of the failure of PHIS or other critical information systems.

Recommendation

2. **Ruth Temple Health Center management work with Department of Public Health Community Health Services administration to create and implement a written set of operational procedures in case of the failure of the Public Health Information System or other critical information systems.**

Conclusion

We shared our findings with DPH's Privacy Officer and CHS on February 19, 2016. Overall, while our review indicates there were minor areas of noncompliance, DPH has initiated substantial efforts to comply with HIPAA Privacy regulations, as indicated by their attached response. We will follow up with DPH's Privacy Officer and CHS in 120 days from the date of this report to ensure all findings have been addressed. We thank DPH's Privacy Officer, as well as CHS and Ruth Temple managers and staff for their cooperation and assistance during this review.

[6] 45 CFR § 164.308(a)

Please call me if you have any questions, or your staff may contact Linda McBride, CHPO, at (213) 974-2166.

JN:AB:PH:RGC:LTM:TW

Attachments

c: Sachi A. Hamai, Chief Executive Officer
Mary C. Wickham, County Counsel
Mitchell H. Katz, M.D., Director, LA County Health Agency
Audit Committee
Health Deputies

HIPAA AND HITECH ACT PRIVACY COMPLIANCE REVIEW
RUTH TEMPLE HEALTH CENTER
SUMMARY OF FINDINGS AND RESULTS

The following table summarizes Ruth Temple Health Center's compliance in each of the nine areas we assessed during our review:

Regulatory Area Reviewed	Result
Notice of Privacy Practices for protected health information (PHI) – 45 Code of Federal Regulations (CFR) § 164.520(c)	Compliant
Safeguards for PHI – 45 CFR § 164.530(c)	Compliant
Training – 45 CFR § 164.530(b)	Compliant
Complaint process – 45 CFR § 164.530(d)	Compliant
Uses and disclosures requiring authorization – 45 CFR § 164.508(a)	Compliant
Accounting for disclosures of PHI – 45 CFR § 164.528(a)	Minor Compliance Issue Recommendation: Ruth Temple management ensure that an accounting for disclosures log has been placed in each patient's medical chart.
HITECH Act breach notification – 45 CFR § 164.400-414	Compliant
Appropriate access to electronic PHI – 45 CFR § 164.308(a)(3)(i)	Compliant
Contingency plan – 45 CFR § 164.308(a)	Minor Compliance Issue Recommendation: Ruth Temple management work with Department of Public Health Community Health Services administration to create and implement a written set of operational procedures in case of the failure of the Public Health Information System, or other critical information systems.

County of Los Angeles – Department of Public Health
Bureau of Disease Control
Community Health Services

Date: 03-08-16

To: Eleanor Lehnkering
DPH Compliance Officer

From: Deborah Davenport
Director, CHS

SUBJECT: HIPAA AND HITECH ACT PRIVACY COMPLIANCE REVIEW – RUTH TEMPLE HEALTH CENTER DRAFT DATED 02-XX-16

Thank you for sending this draft report. The CHS response and corrective actions taken are outlined below.

1. Recommendation: Ruth Temple ensure that an accounting of disclosures log has been placed in each patient's medical chart.

   Response:
   - The Business Office Manager at Dr. Ruth Temple Health Center has instructed staff to assure that all patient charts include the disclosure logs. Gary Reyes from my office conducted a conference call on 03-08-16 with all CHS health center Business Office Managers and Asst. Staff Analysts for the SPAs to assure that the use of disclosure logs are in place in records for all new patients, returning patients, and any requests for release of information. Mr. Reyes will be conducting chart reviews in all health centers beginning this week and completed by 03-18-16.
   - We have initiated Policy #316: Accounting of Disclosure Log (please see attachment)

2. Recommendation: Ruth Temple management work with DPH Community Health Services administration to create and implement a written set of operational procedures in case of the failure of the Public Health Information System (PHIS) or other critical information systems.

   Response:
   - We have initiated a policy to address this issue: Policy 1000: PHIS Downtime Registration Process (please see attachment)

Both policies are being posted to the CHS Policy and Procedure manual on our intranet site with a notice to all managers to review the policies with their staff. These are also part of the agendas for upcoming CHS manager meetings:
Medical Staff: Area Medical Directors meeting 04-0616
Nursing Staff: Area Nurse Managers meeting 04-05-16
Business Office Staff: ASAs and Business Office Managers meeting 03-11-16

Please let me know if you have any concerns or questions.

(Attachments – 2 via email)

DEPARTMENT OF PUBLIC HEALTH
COMMUNITY HEALTH SERVICES
MEDICAL RECORDS POLICIES & PROCEDURES

POLICY NO. 316

SUBJECT: **ACCOUNTING OF DISCLOSURE LOG**

PURPOSE: To establish Community Health Services (CHS) Accounting of Disclosure Procedures that ensure all medical record charts include an Accounting of Disclosure Log (Attachment I) and that the log is utilized accordingly.

PROCEDURE: Business Office clerical staff are responsible in including the Accounting of Disclosure Log to all "NEW" patient medical record charts.

Business Office clerical staff when preparing all "RETURN" patient medical record charts for clinic visit must include the Accounting of Disclosure Log in the medical record chart, if not in place.

A patient information sticker/label will be affixed at the bottom right hand corner of the Accounting of Disclosure log by the Business Office clerical staff during medical record chart preparation prior to clinic visit.

Business Office clerical staff are also responsible to document disclosures on the Accounting of Disclosure Log when the following situation arises that requires access to patient medical record charts. (Please refer to County of Los Angeles Department of Public Health Notice of Privacy Practices booklet for more detailed information, Attachment II).

1. For treatment
2. For Payment
3. For Health Care Operations
4. To Business Associates
5. For Appointment Reminders
6. To Discuss Treatment, Alternatives and Other Health-Related Benefits and Services with You
7. For Fundraising
8. To Individuals Involved in your Care or Payment of Your Care
9. For Disaster Relief Purposes
10. For Public Health Purposes

APPROVED:

DEPARTMENT OF PUBLIC HEALTH
COMMUNITY HEALTH SERVICES
MEDICAL AND NURSING POLICIES & PROCEDURES

POLICY NO. 316

SUBJECT: ACCOUNTING OF DISCLOSURE LOG

11. For Health Oversight Purpose
12. For Research
13. For Judicial and Administrative Proceedings
14. For Law Enforcement Activities
15. Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations
16. To Avert a Serious Threat to Health And Safety
17. To Military Personnel and For National Security
18. For Worker's Compensation Matters
19. As Required by Law
20. About Inmates
21. For Breach Notification
22. Special Rules for Disclosure of Psychiatric, Substance Abuse, and HIV-Related Information

REFERENCES:

County of Los Angeles Department of Public Health Notice of Privacy Practices Booklet (H-3066) HIPAA Guidelines

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
COMMUNITY HEALTH SERVICES

ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

DATE OF DISCLOSURE	NAME OF ENTITY RECEIVING PHI	ADDRESS & PHONE NUMBER OF ENTITY RECEIVING PHI	DESCRIPTION OF PHI DISCLOSED	STATEMENT OF PURPOSE OF DISCLOSURE

DEPARTMENT OF PUBLIC HEALTH
COMMUNITY HEALTH SERVICES
INFORMATION TECHNOLOGY POLICIES & PROCEDURES

POLICY NO. 1000

SUBJECT: PHIS DOWNTIME REGISTRATION PROCESS

PURPOSE: To delineate responsibility and standardize the procedures to be followed in the event that the CHS patient registration system, Public Health Information System (PHIS), is unavailable.

POLICY: All CHS workforce members, who are authorized users of PHIS, will comply with the standards established when PHIS is not operational, planned or unplanned, to minimize interruptions to patient care and maintain the integrity of the record.

DEFINITIONS:

Downtime: The period of time when PHIS is unavailable for patient registration.

- Downtime is either scheduled or unscheduled.
- Scheduled Downtime: PHIS is not available for use due to scheduled maintenance, which will be:
- Announced one week before the scheduled downtime period.
- Approved by key CHSA and/or DPH IT staff.
- Unscheduled Downtime: PHIS is unavailable for use due to an unplanned event, which may occur at any time during the day or night, and may involve all or part of the PHIS application or interfaces.

PHIS: Public Health Information System, which is the CHS patient registration system.

HMS: The software provider for PHIS.

Recovery: The process by which patient information documented during Downtime is entered into PHIS once the system is back up.

APPROVED: 

DEPARTMENT OF PUBLIC HEALTH
COMMUNITY HEALTH SERVICES
MEDICAL AND NURSING POLICIES & PROCEDURES

POLICY NO. 1000

SUBJECT: PHIS DOWNTIME REGISTRATION PROCESS

Back entry: Manual entry of patient data into PHIS that was documented on a paper source during a Downtime.

PROCEDURE:

Health Center and Staff Preparation

1. Each CHS workforce member shall be aware of their responsibilities and the actions they should take if there is PHIS downtime. Downtime procedures will be part of the annual re-orientation of each workforce member who uses the system to perform his or her job.

2. Business Office (BO) Supervisor, or designee, shall inform DPH IT and HC clinic staff that PHIS is down, and get an estimated time when PHIS will be working again from DPH IT.

3. Back entry of data must be completed within 24 hours of PHIS being returned to normal operation by the BO staff.

4. For Scheduled Downtime, BO staff will print the Encounter Form, patient labels, and specimen labels for those patients that are scheduled for a HC clinic visit. For walk-in patients, BO staff shall inform them that the system is down and ask the patients to come back on another day.

Initializing Downtime Procedures

1. DPH IT staff will communicate both scheduled and unscheduled downtime of PHIS to CHS Administration (CHSA) staff, who will inform the Area Medical Directors (AMD), Area SPA Administrators (ASA), Facility Administrators (FA), and Supervising Clinic Nurses (SCN).

2. FA's will be responsible for filing a DPH Incident Report.

3. AMD's will be responsible for calling the CHS Pharmacy to let them know that clinic visits and subsequent prescriptions will be entered manually into PILS, while PHIS is down.

4. Each affected HC will implement their downtime procedures.

5. DPH IT will inform HMS that PHIS is down, and obtain an estimated time of recovery from HMS.

6. DPH IT will inform the BO Supervisor, or designee, when PHIS will be working again.

Registration during Downtime

1. Registration (Opening): Register the patient at the registration window by asking the following questions:

   A. Is this your first visit to the facility? **If No:**

      1. Request any document with their Medical Record Number (MRN) If not available proceed to register as a new patient. **(See section "B")**
      2. Annotate the patient has been here before on Encounter form (for lab purposes)
      3. Request patient to complete Patient Information and General Consent forms
      4. Request patient ID (to verify information however not mandatory for service)
      5. Pull patient medical record chart

SUBJECT: PHIS DOWNTIME REGISTRATION PROCESS

6. Manually fill out encounter form (fill in patient's name, DOB, medical record number and mark "X" in the appropriate boxes).
7. Annotate name and DOB on Daily Tracer Log **(See appendix)**
8. Determine registration number based on the numerical sequence according to the daily tracer log
9. Annotate patient's name DOB and MRN on Daily Tracer Log
10. Send patient to designated clinic along with encounter form
11. Walk medical record chart to clinic
12. The patient's demographics will be updated when PHIS is back up.

B. Is this your first visit to the facility? **If Yes:**

1. Request patient to complete the Patient Information, General Consent and HIPAA form
2. Request patient ID (to verify information however not mandatory for service)
3. Annotate on the bottom right of the Patient Information, General Consent and HIPAA forms the patient's name and DOB.
4. Manually write in the patient's name and DOB on yellow out card and on all forms pertaining to its respective clinic
5. Place forms in the yellow out card
6. Manually fill out encounter form (fill in patient's name, DOB and mark "X" in the appropriate boxes).
7. Annotate name and DOB on Daily Tracer Log
8. Determine registration number based on the numerical sequence according to the daily tracer log

9. Send patient to designated clinic with yellow out card containing forms to drop in clinic drop box

2. Registration (Closing) After Clinic Visit
   A. Collect Half Charts from clinics
   B. The patient's demographics will be updated when PHIS is back up.
   C. Generate a medical record number
   D. Print out label
   E. Create a medical record chart
   F. Transfer all forms into the created hard cover medical chart
   G. Print new encounter form and forward to clinic for completion

3. Triage or Immunization
   A. Create or look up CAIR number and proceed with step A or B

4. Return Appointment
   A. If a patient has a return appointment for a specific clinic date and session, manually complete encounter form
   B. Check off or write name and DOB on appropriate clinic tracer
   C. Send patient to designated clinic with encounter form

Clinical Documentation during Downtime

1. Clinical documentation will be completed and placed in the patient chart, as usual.

2. The Encounter Form shall be completed, as usual. BO staff will store the forms, by visit date, and scan them into PHIS when it is operational.

3. For laboratory and radiology procedures, re-schedule the patient.

4. For pharmacy orders, manually enter patients and prescriptions into PILS.

Recovery from Downtime

After a period of downtime (scheduled or unscheduled) the BO staff will begin the recovery process. This process is used to update PHIS with the information collected on various forms, while the system was unavailable.

The recovery process can begin as soon as PHIS is available.

1. The Encounter Form shall be scanned into PHIS by the BO staff.

2. For laboratory and radiology procedures, patients can be scheduled for visits.

Back entry of patient registration data and scanning of Encounter Forms must be completed within 24 hours of PHIS being returned to normal operation.

1. The BO Supervisor shall inform the FA of completion of back entry of PHIS downtime data. The FA will inform their respective ASA, who will provide an update to CHSA staff.

2. If back entry cannot be completed within 24 hours of PHIS recovery, the FA shall provide a daily status report of completion to the ASA, who will provide a daily status report update to CHSA staff.

Once recovery is complete, CHSA staff will notify the CHS Director.